Forty-eighth Legislature
Second Regular Session

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1079

(Reference to Senate engrossed bill)

Strike everything after the enacting clause and insert:

"Section 1. Section 36-2901.03, Arizona Revised Statutes, is amended to read:

36-2901.03. Federal poverty program; eligibility

A. The administration shall adopt rules for a streamlined eligibility determination process for any person who applies to be an eligible person as defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The administration shall adopt these rules in accordance with state and federal requirements and the section 1115 waiver.

B. The administration must base eligibility on an adjusted gross income that does not exceed one hundred per cent of the federal poverty guidelines.

C. For persons who the administration determines are eligible pursuant to this section, the date of eligibility is the first day of the month of application.

D. Except as provided in ~~subsection~~ SUBSECTIONS E AND F of this section, the administration shall determine an eligible person's continued eligibility ~~on an annual basis~~ AT LEAST ANNUALLY.

E. Every six months the administration shall determine the continued eligibility of any adult who is at least twenty-one years of age and who is subject to redetermination of eligibility for temporary assistance for needy families cash benefits by the department. Acute care redeterminations pursuant to this subsection shall begin on ~~the effective date of this amendment to this section~~ SEPTEMBER 19, 2007 and shall occur simultaneously with redeterminations of eligibility for temporary assistance for needy families cash benefits.

F. EVERY SIX MONTHS THE ADMINISTRATION SHALL DETERMINE THE CONTINUED ELIGIBILITY OF ANY ADULT WITHOUT DEPENDENT CHILDREN WHO IS ALL OF THE FOLLOWING:

1. AT LEAST TWENTY-ONE YEARS OF AGE.

2. DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901.01.

3. NOT OTHERWISE ELIGIBLE AS A MANDATORY OR OPTIONALLY ELIGIBLE MEMBER PURSUANT TO TITLE XIX OF THE SOCIAL SECURITY ACT AS AUTHORIZED BY THE STATE PLAN.

Sec. 2. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),

(d) and (e). ~~In the absence of a willing contractor~~ IN COUNTIES WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with one eligible employee or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of one and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

C. The administration shall not enroll an employer group in healthcare group sooner than one hundred eighty days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the one hundred eighty day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

D. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. Medical assistance is provided pursuant to section 36-2982, subsection I.

E. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

F. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

G. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

H. The administration shall provide eligible employees with disclosure information about the health benefit plan.

I. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. Beginning on July 1, 2005, require that a contractor, the administration or an accountable health plan negotiate reimbursement rates and not use the administration's reimbursement rates established pursuant to section 36-2903.01, subsection H, as a default reimbursement rate if a contract does not exist between a contractor and a provider.

3. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

4. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

5. Adopt rules.

6. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

J. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall provide a health benefit plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan and contract. The administration shall offer to all small employers the available health benefit plan and shall accept any small

employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

L. The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

M. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

N. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

O. The administration ~~may~~ SHALL increase or decrease premiums based on actuarial reviews BY AN INDEPENDENT ACTUARY of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. ~~The administration may cap the amount of the change.~~ FOR EACH CONTRACT PERIOD THE ADMINISTRATION SHALL SET PREMIUMS THAT IN THE AGGREGATE COVER PROJECTED MEDICAL AND ADMINISTRATIVE COSTS FOR THAT CONTRACT PERIOD AND THAT ARE DETERMINED PURSUANT TO GENERALLY ACCEPTED ACTUARIAL PRINCIPLES AND PRACTICES BY AN INDEPENDENT ACTUARY.

P. The administration ~~may~~ SHALL consider age, sex, ~~income~~ GROUP SIZE, GEOGRAPHIC AREA and community rating when it establishes premiums for the healthcare group program.

Q. Except as provided in subsection R of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based

on a person's health status-related factors or a lack of evidence of insurability. A HEALTH BENEFIT PLAN SHALL NOT PROVIDE OR OFFER ANY SERVICE, BENEFIT OR COVERAGE THAT IS NOT A PART OF THE HEALTH BENEFIT PLAN CONTRACT.

R. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

S. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

T. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

U. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

V. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For THE purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

W. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.

X. The healthcare group program shall comply with all applicable federal requirements.

Y. Healthcare group may pay a commission to an insurance producer. To receive a commission, the producer must certify that to the best of the producer’s knowledge the employer group has not had insurance in the one hundred eighty days before applying to healthcare group. For the purposes of this subsection, "commission" means a one time payment on the initial enrollment of an employer.

Z. On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

AA. THE ADMINISTRATION SHALL SUBMIT THE FOLLOWING TO THE JOINT LEGISLATIVE BUDGET COMMITTEE:

1. QUARTERLY REPORTS REGARDING THE FINANCIAL CONDITION OF THE HEALTHCARE GROUP PROGRAM. THE REPORTS SHALL INCLUDE THE NUMBER OF PERSONS AND EMPLOYER GROUPS ENROLLED IN THE PROGRAM AND MEDICAL LOSS INFORMATION AND PROJECTIONS.

2. AN ANNUAL FINANCIAL AUDIT.

3. AN ANNUAL WRITTEN STATEMENT BY A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES CERTIFYING THAT, BASED ON AN EXAMINATION BY THE INDIVIDUAL, INCLUDING A REVIEW OF THE APPROPRIATE RECORDS AND OF THE ACTUARIAL ASSUMPTIONS AND METHODS USED BY THE INDEPENDENT ACTUARY IN ESTABLISHING BASE PREMIUM RATES AND PREMIUM RATES FOR HEALTH BENEFITS PLANS:

(a) THE HEALTH BENEFIT PLAN IS IN COMPLIANCE WITH THE APPLICABLE PROVISIONS OF THIS SECTION.

(b) THE RATING METHODS ARE ACTUARIALLY SOUND.

~~AA.~~ BB. For the purposes of this section:

1. "Accountable health plan" has the same meaning prescribed in section 20-2301.

2. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan, as defined in section 20-2301, issued by a health plan.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care

services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(m) A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.

4. "Eligible employee" means a person who is one of the following:

(a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(b) A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.

(c) An employee who elects coverage pursuant to section 36-2982, subsection I. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection I does not apply to this subdivision.

(d) A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.

5. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct ~~analysis~~ ANALYSES of genes or chromosomes.

6. "Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.

7. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

8. "Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.

9. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment

is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.

(c) The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

10. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

11. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.

12. "Small employer" means an employer who employs at least one but not more than fifty eligible employees on a typical business day during any one calendar year.

13. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 3. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2912.04, to read:

36-2912.04. Medical loss subsidies; required information

THE ADMINISTRATION SHALL ESTABLISH UTILIZATION MANAGEMENT CONTROL STANDARDS FOR PARTICIPATING CONTRACTORS THAT MEET NATIONALLY RECOGNIZED STANDARDS FOR MANAGED CARE UTILIZATION. CONTRACTORS THAT DO NOT MEET THESE STANDARDS ARE NOT ELIGIBLE FOR STOP-LOSS COVERAGE FOR MEDICAL COSTS IN EXCESS OF THESE STANDARDS.

Sec. 4. Healthcare group; temporary enrollment freeze

Notwithstanding section 36-2912, Arizona Revised Statutes, as amended by this act, beginning August 1, 2008 and ending on July 31, 2011, healthcare group shall not enroll any additional employer groups defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), Arizona Revised Statutes.

Sec. 5. County transfers; fiscal year 2008-2009

Notwithstanding any other law, in fiscal year 2008-2009, counties with a population of two million or more persons shall transfer $17,497,300 and counties with a population of more than eight hundred thousand persons but less than two million persons shall transfer $4,854,200 to the Arizona health care cost containment system administration for deposit in the budget neutrality compliance fund established by section 36-2928, Arizona Revised Statutes.

Sec. 6. AHCCCS; disproportionate share payments

Disproportionate share payments for fiscal year 2008-2009 made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, include:

1. $89,877,700 for a qualifying nonstate operated public hospital. The Maricopa county special health care district shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the administration on or before June 1, 2009. The administration shall assist the district in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Maricopa county special health care district, if the certification is equal to or greater than $89,877,700, the administration shall distribute $4,202,300 to the Maricopa county special health care district and deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than $89,877,700, and the administration determines that the revised amount is correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives, shall distribute $4,202,300 to the Maricopa county special health care district and shall deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than $89,877,700 and the administration determines that the revised amount is not correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the total amount of the federal funds participation in the state general fund.

2. $28,614,300 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of the state to the administration on or before March 31, 2009. The administration shall assist the Arizona state hospital in determining the amount of

qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Arizona state hospital, the administration shall distribute the entire amount of federal financial participation to the state general fund. If the certification provided is for an amount less than $28,614,300, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall distribute the entire amount of federal financial participation to the state general fund. The certified public expense form provided by the Arizona state hospital shall contain both the total amount of qualifying disproportionate share hospital expenditures and the amount limited by section 1923(g) of the social security act.

3. $26,147,700 for private qualifying disproportionate share hospitals.

Sec. 7. County acute care contribution; fiscal year 2008-2009

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2008-2009 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$21,552,700
9.	Mohave	$ 1,237,700
10.	Navajo	$ 310,800
11.	Pima	$14,951,800
12.	Pinal	$ 2,715,600
13.	Santa Cruz	$ 482,800
14.	Yavapai	$ 1,427,800
15.	Yuma	$ 1,325,100

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes, from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirements as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer shall not withhold distributions from the highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the amounts paid pursuant to subsection C of this section and amounts withheld pursuant to subsection B of this section in the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

E. If payments made pursuant to subsection C of this section exceed the amount required to meet the costs incurred by the Arizona health care cost containment system for the hospitalization and medical care of those persons defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the Arizona health care cost containment system administration may instruct the state treasurer either to reduce remaining payments to be paid pursuant to this section by a specified amount or to provide to the counties specified amounts from the Arizona health care cost containment system fund and the long-term care system fund.

F. It is the intent of the legislature that the Maricopa county contribution pursuant to subsection A of this section be reduced in each subsequent year according to the changes in the GDP price deflator. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563, Arizona Revised Statutes.

Sec. 8. ALTCS; county contributions

Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2008-2009 are as follows:

1.	Apache	$ 631,900
2.	Cochise	$ 5,673,800
3.	Coconino	$ 1,896,000
4.	Gila	$ 2,352,400
5.	Graham	$ 1,216,100
6.	Greenlee	$ 118,900
7.	La Paz	$ 890,300
8.	Maricopa	$161,590,300
9.	Mohave	$ 8,441,300
10.	Navajo	$ 2,614,000
11.	Pima	$ 41,487,700
12.	Pinal	$ 12,972,300
13.	Santa Cruz	$ 1,939,800
14.	Yavapai	$ 9,260,600
15.	Yuma	$ 6,902,400

Sec. 9. Hospitalization and medical care contribution; fiscal year 2008-2009

A. Notwithstanding any other law, for fiscal year 2008-2009, beginning with the second monthly distribution of transaction privilege tax revenues, the state treasurer shall withhold the following amounts from state transaction privilege tax revenues otherwise distributable, after any amounts withheld for the county long-term care contribution or the county administration contribution pursuant to section 11-292, subsection P, Arizona Revised Statutes, for deposit in the Arizona health care cost containment system fund established by section 36-2913, Arizona Revised Statutes, for the provision of hospitalization and medical care:

1.	Apache	$ 87,300
2.	Cochise	$ 162,700
3.	Coconino	$ 160,500
4.	Gila	$ 65,900
5.	Graham	$ 46,800
6.	Greenlee	$ 12,000
7.	La Paz	$ 24,900
8.	Mohave	$ 187,400
9.	Navajo	$ 122,800
10.	Pima	$1,115,900
11.	Pinal	$ 218,300
12.	Santa Cruz	$ 51,600
13.	Yavapai	$ 206,200
14.	Yuma	$ 183,900

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirement as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer shall not withhold distributions from the highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total monies prescribed pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the monies paid pursuant to subsection C of this section in the Arizona health care cost containment system fund established by section 36-2913, Arizona Revised Statutes.

E. In fiscal year 2008-2009, the sum of $2,646,200 withheld pursuant to subsection A or B of this section, as applicable, is allocated for the county acute care contribution for the provision of hospitalization and medical care services administered by the Arizona health care cost containment system administration.

F. County contributions made pursuant to subsection A of this section are excluded from the county expenditure limitations.

Sec. 10. Child care eligibility levels; report

Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal year 2008-2009, the department of economic security may reduce maximum income eligibility levels for child care assistance in order to manage within appropriated and available monies. The department shall notify the joint legislative budget committee of any change in maximum income eligibility levels for child care within fifteen days after implementing that change.

Sec. 11. Competency restoration treatment; county and city reimbursement; fiscal year 2008-2009; deposit; tax withholding

A. Notwithstanding section 13-4512, Arizona Revised Statutes, if the state pays the costs of a defendant's inpatient competency restoration treatment pursuant to section 13-4512, Arizona Revised Statutes, for counties with a population of eight hundred thousand or more persons and for all cities, the city or county shall reimburse the department of health services for eighty-six per cent of these costs for fiscal year 2008-2009.

B. The department shall deposit the reimbursements, pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state hospital fund established by section 36-545.08, Arizona Revised Statutes.

C. Each city and county shall make the reimbursements for these costs as specified in subsection A of this section within thirty days after a request by the department. If the city or county does not make the reimbursement, the superintendent of the Arizona state hospital shall notify the state treasurer of the amount owed and the treasurer shall withhold the amount, including any additional interest as provided in section 42-1123, Arizona Revised Statutes, from any transaction privilege tax distributions to the city or county. The treasurer shall deposit the withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state hospital fund established by section 36-545.08, Arizona Revised Statutes.

Sec. 12. Proposition 204 administration; county expenditure limitation

County contributions for the administrative costs of implementing sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made pursuant to section 11-292, subsection O, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 13. Health insurance premiums; department of administration

For fiscal year 2008-2009, the department of administration shall not implement a differentiated health insurance premium based on the integrated or nonintegrated status of a health insurance provider available through the state employee health insurance program beginning October 1, 2008.

Sec. 14. Health insurance benefits; legislative approval; retroactivity

A. Notwithstanding any other law, the department of administration shall not make changes to the benefit design or eligibility of the health insurance benefit program in fiscal year 2008-2009 unless those changes have been approved by the legislature.

B. This section is effective retroactively to from and after December 31, 2007.

Sec. 15. Eligibility; benefit levels; enrollment; agencies

Notwithstanding any other law, the Arizona health care cost containment system, the department of economic security and the department of health services may change the eligibility or benefit level of programs, or freeze enrollment in programs, in order to comply with the agencywide lump sum reduction for their agency in the fiscal year 2008-2009 general appropriation act. Changes made to the eligibility or benefit level of programs, or an enrollment freeze, shall not conflict with federal law or be in violation of the provisions of article IV, part 1, section 1, Constitution of Arizona."

Amend title to conform

and, as so amended, it do pass

RUSSELL K. PEARCE
Chairman

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6/25/08
H:jmb

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06/23/2008
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